SPECIAL REPORT NO. NIS-4

Health Financing in the Newly Independent States: Options and Experience

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Health Financing Reforms in the Newly Independent States: Options and Experience

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Executive Summary

Jack C. Langenbrunner of Abt Associates Inc. presented findings on options and experiences in health financing reforms in the Newly Independent States at the WHO Manas Conference in Bishkek, Kyrgyzstan in February 1995.

Health care financing reforms have become critical to the former Soviet Union since the late 1980s because of problems in both sources and uses of funds. Two important developments, the New Economic Mechanism program and new health insurance and reform legislation, provide options and alternatives to the former Soviet Union system.

One basic health financing problem facing NIS countries regarding the source of funds is an overdependence on the government based centralized budget process. Alternatives developed in the last few years in response to these problems include one line payments, diversification of revenue sources, and self-sustaining public or insurance funds. While each alternative has increased flexibility and increased opportunities for new sources of funding, each also has problems that require consideration.

The Soviet approach to health care delivery emphasized quantitative rather than qualitative goals, which had significant impacts on uses of funds. The Soviet approach biased the system towards mis-allocation of resources, and toward more expensive inpatient care and specialty care. However, there are many alternatives to the Soviet approach to resource allocation. One is a case based payment and another is fund holding. Both have been tried in parts of former NIS countries. Results indicate that each has distinct advantages and disadvantages, oftentimes depending on settings, such as rural or urban areas.

Slides used in the presentation are included in this document.

Introduction

Mr. Speaker, Members of the Manas Team, Ladies and Gentlemen. Thank you very much for inviting me to speak today. It is a pleasure and honor to be here with you. It also is wonderful to be back here again in your beautiful country.

[OVERHEAD 1 HERE]

Dr. Joseph Kutzin has just described financing issues that other countries have had to address in their attempts to achieve a delivery system that is both efficient and equitable. During this next session, I hope we can accomplish the following:

1) discuss health financing issues, but specifically in the context of the Newly-Independent States (NIS) countries, such as the Russian Federation and the Central Asian republics;

2) focus on some of the experiments that have evolved over the last few years and some of the innovations that have developed as a result;

3) discuss both the benefits and the drawbacks of these experiments, especially in the context of policy options that this country's leadership will be considering over the next few months and years;

4) finally, Dr. Michael Borowitz, director of the Zdrav*Reform* Program office in Almaty, will discuss some of the financing issues related to two ongoing health reform demonstrations—one in South Kazakhstan oblast in Kazakhstan and one in Issyk-Kul oblast here in Kyrgyzstan.

I hope our talks can provide a good lead-in to a rich discussion with all of you on financing issues related to health reform here in Kyrgyzstan.

I look forward to your ideas and comments over the next two hours.

Defining Financing Issues

[OVERHEAD 2 HERE]

For my part of this session, I will discuss financing issues on two levels or in terms of two aspects of financing:

1) Sources of funds, or the revenues available for health care services;

2) Uses of funds, or the actual payment for health care services.

Sources of funds for health care in Western nations are typically derived from a mix of government funds, employers, and individuals. In the NIS countries until recently, only public sector or government budgets provided sources of revenue. The uses of funds refers to levels of spending for care (e.g., per capita, percent of GDP) as well as patterns of spending for services (e.g., salaries, equipment, pharmaceuticals).

Together the sources of funds and uses of funds will be equally critical in determining the adequacy of financing for organizing and delivering health services. While decisionmakers—especially in the NIS countries—tend to focus on the new *sources* of revenues, any evaluation or assessment of the *adequacy of financing* in terms of need must include an examination of the prudent use of resources. That is to say, adequacy and longer-term sustainability will be dependent upon how well funds are targeted to encourage a well-organized and managed delivery system.

Defining the Problem: The Old System

[OVERHEAD 3 HERE]

Why have financing issues and financial reforms become so critical?

By the late 1980s there was a growing consensus within the former Soviet Union that the old Soviet system was flawed and was failing along several dimensions. Specifically, there were problems both in terms of *sources* of funds and uses of funds, such as:

- chronic underfunding;
- lack or absence of efficiency and use of incentives;
- maldistribution of resources, both in terms of
    - over investments in physicians and beds;
    - under investments in equipment, supplies, and pharmaceuticals;
- overly bureaucratized and centralized decisionmaking.

Two important developments came out of these concerns over the last several years. They include:

- the New Economic Mechanism program. Initiated out of Moscow, this program provided oblasts greater flexibility in terms of uses of funds for services. In Russia, for example, Kemerovo, St. Petersburg, and Samara each participated in financing

demonstrations. Three to four oblasts in Central Asia also participated; Issyk-Kul oblast designed a demonstration but never implemented it.

- new health insurance and reform legislation such as in Kyrgyzstan and the Russian Federation, to better assure stability in the sources of funds for health care.

Both of these developments provided options and alternatives to moving beyond the old (and often still current) system. I want to discuss some of these options and alternatives in terms of the *sources* and uses of funds.

Financing: Sources of Funds

Issues and Problems

[OVERHEAD 4 HERE]

The basic problem has been an overdependence on the government-based centralized budget process. The old Soviet system allocated funds for health protection on a residual basis from general tax revenues; levels of funds were determined only after budgets were allocated for other "productive" sectors such as industry, manufacturing, and defense. Secondly, over the last several years, national independence and the general economic decline in many NIS countries have exacerbated the issue of underfunding since the revenue base has deteriorated. Together, these factors have contributed to a fall in spending both in absolute terms and as a percentage of gross domestic product (GDP)—from about 6 percent in the mid-1980s to about 1 or 2 percent in more recent years. An emerging funding crisis in health services has resulted.

For facilities and providers, this dependence on the government-based centralized budget process meant that they have received monies in the form of overly-restrictive 18-line item budget chapters—such as salaries, food, and pharmaceuticals. These funds had to be spent according to each line item and regardless of real need or demands faced by facilities and providers during the course of the fiscal year.

Emerging Alternatives

[OVERHEAD 5 HERE]

Some of the alternatives that have developed in the last few years in response to these problems include:

- One-line payments, or capitation payments from the government and either to a separate fund (e.g., the Territorial Health Insurance Fund in Russia) or to the provider directly. This has increased both the flexibility for and the prudent use of resources by the recipient;

- Diversification of revenue sources-such as 1) user fees and direct charges for services; 2) employer-based payroll taxes for the working population (often 3-6 percent of payroll), such as in Issyk-Kul and elsewhere; 3) voluntary or private insurance, as in South Kazakhstan oblast and Kemerovo, for supplemental benefits such as choice of provider, pharmaceuticals and amenities; 4) selective contracting by providers with employers for the purpose of increasing choice of provider, improving quality and access of services provided, and increasing the amenities of care such as semi-private rooms and better food.

  There is some evidence of activity and increased interest in selective contracting arrangements in Kyrgyzstan. One large 660 bed hospital in Bishkek has already contracted for the use of his facility by seven employer groups for an agreed upon amount of 50,000S in March of last year. The amount covered services per year per group. The contract allows access to the facility's several specialty units and surgical facilities. These groups also have a choice of physicians when seeking outpatient care or when admitted for inpatient care. Choice of physician is not an option for patients in the public system. Another administrator discussed the idea of contracts with other facilities for referral services. These contracts reportedly provide revenues for 10-20 percent of a facility's costs depending upon volume.

- Separate, self-sustaining public or social insurance funds. This approach can help 1) pool available funds to lower risk selection, to increase purchasing power and/or to increase equity; 2) increase the sustainability and stability of funding from year-to-year; and 3) separate financing of care from the provision of care. The third point means that the payer can focus on paying for the best care at the lowest cost. The provider can, on the other hand, have more flexibility to focus on delivering the most optimal mix of services with the best outcome.

Impacts and Issues Related to New Alternatives

[OVERHEAD 6 HERE]

While these alternatives have both increased flexibility and increased opportunities for new sources of funding, they have not been free of problems either. For example,

- One-line or capitation payments must address several problematic issues such as

  - how to construct the base year amount of payment. Should this be politically-fixed through legislation or administrative fiat, which potentially adds all the attendant problems of the old process? Should this be based on historical trends, which risk "freezing-in" years of previous underfunding? Or, should there be a determination of need levels of funding, without really knowing (at the same time) an exact method that can be used to measure it?

- how to adequately and fairly update the level of payment for such factors as inflation, demographic changes, practice pattern changes, technology and equipment changes, unexpected epidemiologic events, and so on. Each of these factors can be difficult to measure precisely with incomplete data, which potentially leaves health sector funding vulnerable in future years.

- New sources of funding have several problematic issues, such as:

  - legal strictures that do not allow charging for care or imposing user fees. This is the case in Kazakhstan and in the Russian Federation.

  - new taxes levied can be harmful or have unintended effects. An employer-based payroll tax could curtail the creation of jobs or the formation of capital and lower the longer-run revenue base for funding services. Secondly, it could force companies to avoid the formal economy to avoid taxes, especially if the tax burden is already significant.

    The payroll contribution approach in Dzheskasgan oblast in Kazakhstan faces several challenges. It suffers from less than full participation by all firms, especially smaller ones. Even with participating firms, contributions are not timely. Only about 8 percent of businesses under 100 employees are currently willing to participate in the experiment in Dzheskasgan oblast.

    In Kemerovo, a 6 percent payroll tax faced similar problems; however, when the tax was lowered to 3.6 percent, the amount of funds actually increased, because companies were more willing to pay the lowered tax rate.

    In the short-run, policy makers may need to rethink the tax level, and to what extent the new tax will have negative impacts. In the longer-run, alternative types of taxes should be considered such as “sin” taxes on alcohol and tobacco or sales taxes on consumer goods.

- Voluntary or Private Insurance. Policy makers will need to consider the impact of the mix of public and private insurance on costs, equity, and access.

  In the South Kazakhstan area, the influence of voluntary health insurance has improved quality of care for some through increased availability of pharmaceuticals and diagnostic tests, increased consumer choice, and tougher quality standards.

  However, private insurance cannot provide these improvements at the expense of publicly-insured groups. In terms of quality, it may mean less access for those without voluntary coverage. In terms of costs, supplemental insurance can increase the costs of

public insurance coverage, as is the case with the Medicare program for the elderly in the United States. Supplemental insurance provides coverage for co-payments and deductibles, which in turn effectively increases the demand for care and increases public program expenditures by 17-33 percent.

The challenge will be to design a mixed public and private insurance sector that can provide high quality care and greater consumer choice for all, and not just for those who can afford to opt-out of the public system. This will demand restructuring and management of private markets, such as improved competition among voluntary insurers and the guarantee of availability and renewability of private insurance benefits. It also will demand a restructuring of the public system in more dramatic ways to assure that consumers have choices and that everyone receives some defined minimal level of access and quality services.

- Separate, self-sustaining public or social insurance funds face issues of implementation and fiscal integrity. The new insurance funds system in Russia is in a state of transition and implementation has proceeded at a very uneven pace across oblasts and even within oblasts. The status of implementation often has been uncertain, complex and confused. As of mid-1994, territorial insurance funds existed in 82 (of 89) oblasts, but insurance companies were operating in all or part of only 35 oblasts. Some have completely implemented the reform law (e.g., Kaluga, Kemerovo), others have partially implemented the law (e.g., Tver, Tomsk), and others appear to have little or no intention of implementing the law (e.g., in Smolensk where the new funds are used for pharmaceuticals and major equipment purchase, and Novosibirsk).

  Implementation has been uneven for many and varied reasons, including:

  - socio-economic obstacles, such as inflation, unemployment, and burdensome taxes impeding development of a strong revenue base;
  - funding problems at the local and oblast levels;
  - lack of specificity in the mandated benefit packages;
  - adequacy and non-compliance by employers with the new payroll tax;
  - full integration of the multiple funding bases by the funds themselves;
  - bureaucratic ambiguities and rivalries among levels of governments, regional funds, health insurance companies, and providers;
  - adequacy and accuracy of capitation payments to insurers;

- impediments for insurers to contract with providers;

- general lack of information and lack of technical capacity.

A second general issue has been the prudent management of funds collected by the insurer. The THIF reserve funds have been used for private investments and for other types of insurance such as life and property. There is a risk of shifting public fund revenues to cover costs of other businesses and to cover claims of non-health insurance subscribers. The THIF fund has also been mis-used for purchases of drugs and medical equipment and for subsidies to medical facilities, rather than paying for the most optimal mix of health care services for citizens themselves.

In short, while these alternatives have opened-up new potential channels of funding, they have not been problem-free to date. Even these alternatives will require some careful thinking in terms of *design, implementation,* and *monitoring and management* in the future.

Financing: Uses of Funds

Issues and Problems

Now, let me turn to the *uses* of funds or the way available monies are spent for services. We have already mentioned that the Soviet approach to health care delivery did not encourage the efficient use of resources, due in part to a system which allocated resources based on traditional central planning production input measures such as occupancy and numbers of staff and beds, rather than services performed, relative complexity of services, or changes in health status. An emphasis was placed on *quantitative,* rather than *qualitative* goals. This approach, in turn, biased the system towards mis-allocation of resources—toward more expensive inpatient care and specialty care.

The resulting inefficiency of these approaches can be seen in the graphs noted below. I am indebted to George Schieber for supplying some of these numbers, and I am grateful to Victoria Goldin for creating these graphs. These graphs report the latest available comparisons for selected data and statistics for NIS countries and other OECD-member countries (OECD, or the Organization of Economic Cooperation and Development, countries are largely western, more industrialized nations such as Germany, Great Britain, Sweden, Japan, Canada, and the United States).

[OVERHEADS 7, 8, 9, 10, 11 HERE]

Data from the graphs compare beds per 1,000 population, admissions per capita, average lengths of stay and referrals to hospitals. Each have declined over the past few years, but each remain well-above numbers for other countries. Relative resources devoted to hospital care remains high.

[OVERHEADS 12 and 13 HERE]

Subsequent tables show physicians per 1,000 population and the relative ratio of general practitioners (GPs) to all physicians. These charts reinforce the point that resources are heavily biased toward expensive hospital and physician specialty care versus more cost-effective primary and outpatient-based care. For example, only 12 percent of physicians are GPs; more than half the physicians in Canada, United Kingdom and France are GPs.

Emerging Alternatives

The alternatives to these resource allocation approaches are multiple, many of which have been discussed by several of the speakers of this conference such as Dr. Mark Wheeler and Dr. Joseph Kutzin. There is no need to repeat the alternatives here. In the remaining time, I would like to just mention a few additional experiences to date regarding improved use of funds:

- Case-based payments—one is the use of case-based payment for an inpatient admission, based on the Medical-Economic Standards (MES) or Clinical-Statistical Groups. These have been used in Kemerovo and proposed for many, many other oblast-level systems in the NIS;

- Fund-Holding—another is the use of primary care group fundholding schemes, often referred to as APTKs, the Russian language acronym. These groups are typically composed of an internist, pediatrician, and obstetrician with attendant nurses and staff. These schemes have been demonstrated over the years in St. Petersburg and Kemerovo, and other oblasts.

These case-based payment and fundholding groups are not exclusive approaches. In fact, they have been used together for both hospitals and for physician/outpatient services.

Impacts and Issues Related to New Alternatives

Both approaches have advantages and disadvantages. Case-based payments using the MES are performance-based and are made only upon the successful completion of treatment—often referred to as a "finished case". These also can be adjusted for the complexity or severity of an individual case.

However, there are several distinct disadvantages to this approach as currently used. They include:

- reliance on overly-strict quality control process-based measures that can preclude innovative practice patterns;

- associated payments may not be related to real costs or resource use, but to normative prices based on centralized norms;

- inherent incentives may actually increase inpatient costs and increase inappropriate admissions, if not complemented with counterbalancing incentives for primary and outpatient care.

In Kaluga oblast in Russia, for example, the approach was discontinued once hospital administrators realized that revenues increased with each admission, and that no screens or safeguards were in place to prevent them from admitting patients regardless of patient condition. Abuses were common and costs increased dramatically.

One demonstration which did utilize balancing payment incentives was Dzheskasgan oblast in Kazakhstan, where APTK groups were formed with full capitation payments made to each of these groups per enrollee to cover all inpatient and outpatient services.

In April 1994, we completed a formal evaluation of that demonstration, and found several promising changes and results that pointed to an increased emphasis on primary and outpatient care. I want to share a few of the results here that we found for the period of 1990 through 1993:

- Allocative efficiency changes—or the share of resources going to outpatient vs. inpatient care—were promising:

    - share of visits to APTK's increased from 37 to 51 percent;

    - percentage share of primary care physicians as share of all practicing physicians increased from approximately 20 percent to 35 percent;

    - ratio of visits to hospital admissions increased from 28 percent to 48 percent;

    - the number of hospital admissions decreased by 26 percent;

    - numbers of beds per 1,000 population decreased from 14.7 to 10.2.

    These data tend to confirm our original hypothesis that the APTK physicians would take on an increasing share of the care and that polyclinics would shift the concentration of care to greater provision of primary health care.

- Technical efficiency changes—or for the mix of inputs for a given output—were less positive:

    - average length of stay was essentially unchanged, even after adjusting for case complexity;

- hospital physicians and staff had increased 9 percent, despite reductions in admissions and little or no change in case complexity. In part, this was due to the unwillingness to lay-off staff under central labor normatives and labor union pressures;

- some preventive services such as vaccinations and contraceptive services had decreased slightly.

In short, some fine-tuning may be in order at this demonstration site. For example, "priority services" such as vaccinations could be paid on a fee-for-service or bonus payment basis.

Finally, questions remain about the generalizability of these reforms, both because the approach has not always succeeded (it failed in St. Petersburg) and because it may be more applicable in some settings (e.g., urban areas vs. rural) than in others.

This is a good transitional point for Dr. Michael Borowitz, who will provide us with an update on the design issues and experience related to two demonstration sites in Central Asia-Karakol/Issyk-Kul oblast and South Kazakhstan oblast.

Вопросы финансирования в рамках Сюза Независимых Государств

Проблемы и перспективы